

Facility Name & ID Number Mercer County Nursing Home# 0001396 Report Period Beginning: 3/1/04 Ending: 2/28/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsn/a

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>95</u>	Intermediate (ICF)	<u>95</u>	<u>34,675</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>95</u>	TOTALS	<u>95</u>	<u>34,675</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>17,379</u>	<u>16,060</u>		<u>33,439</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,379</u>	<u>16,060</u>		<u>33,439</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 96.44%

D. How many bed-hold days during this year were paid by the Department?

174 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)none

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1/2/70

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☐Tax Year: N/A Fiscal Year: 2/28/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number

Mercer County Nursing Home

0001396

Report Period Beginning:

3/1/04

Ending:

2/28/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	183,510	19,845	6,252	209,607		209,607		209,607		1
2	Food Purchase		203,116		203,116		203,116	(10,891)	192,225		2
3	Housekeeping	192,444	10,853		203,297		203,297		203,297		3
4	Laundry	30,823	3,714	16,875	51,412		51,412		51,412		4
5	Heat and Other Utilities			83,898	83,898		83,898		83,898		5
6	Maintenance	27,536	11,003	61,054	99,593		99,593	(12,853)	86,740		6
7	Other (specify):*										7
8	TOTAL General Services	434,313	248,531	168,079	850,923		850,923	(23,744)	827,179		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,388,775	83,864	37,537	1,510,176		1,510,176		1,510,176		10
10a	Therapy			2,874	2,874		2,874		2,874		10a
11	Activities	79,038	6,361	2,118	87,517		87,517		87,517		11
12	Social Services	23,569		3,636	27,205		27,205		27,205		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,491,382	90,225	46,165	1,627,772		1,627,772		1,627,772		16
	C. General Administration										
17	Administrative	57,162			57,162		57,162		57,162		17
18	Directors Fees										18
19	Professional Services			25,723	25,723		25,723		25,723		19
20	Dues, Fees, Subscriptions & Promotions			7,861	7,861		7,861		7,861		20
21	Clerical & General Office Expenses	55,216	7,732	16,935	79,883		79,883	(150)	79,733		21
22	Employee Benefits & Payroll Taxes			696,204	696,204		696,204		696,204		22
23	Inservice Training & Education			60	60		60		60		23
24	Travel and Seminar			2,983	2,983		2,983		2,983		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			95,400	95,400		95,400		95,400		26
27	Other (specify):*										27
28	TOTAL General Administration	112,378	7,732	845,166	965,276		965,276	(150)	965,126		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,038,073	346,488	1,059,410	3,443,971		3,443,971	(23,894)	3,420,077		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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#0001396

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			80,287	80,287		80,287	(5,433)	74,854			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,275	5,275		5,275	(5,275)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			85,562	85,562		85,562	(10,708)	74,854			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			16,737	16,737		16,737		16,737			40
41	Coffee and Gift Shops			2,908	2,908		2,908		2,908			41
42	Provider Participation Fee			52,061	52,061		52,061		52,061			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			71,706	71,706		71,706		71,706			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,038,073	346,488	1,216,678	3,601,239		3,601,239	(34,602)	3,566,637			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

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0001396

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(10,891)	2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income	(5,275)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(150)	21		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 CNA Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(18,286)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (34,602)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
Amortization of Organization &			
33 Pre-Operating Expense			33
Adjustments for Related Organization			
34 Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (34,602)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	architects fees for assisted living complex	\$ (12,853)	6	1
2	depreciation on disallowed capital expense	(5,433)	30	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(18,286)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mercer County Nursing Home

0001396

Report Period Beginning:

3/1/04

Ending:

2/28/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,891)	0	0	0	0	0	0	0	0	0	0	(10,891)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(12,853)	0	0	0	0	0	0	0	0	0	0	(12,853)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(23,744)	0	0	0	0	0	0	0	0	0	0	(23,744)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(150)	0	0	0	0	0	0	0	0	0	0	(150)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(150)	0	0	0	0	0	0	0	0	0	0	(150)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(23,894)	0	0	0	0	0	0	0	0	0	0	(23,894)	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Mercer County Nursing Home# 0001396

Report Period Beginning:

3/1/04

Ending:

2/28/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Mercer County</u>	<u>100</u>					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercer County Nursing Home # 0001396 Report Period Beginning: 3/1/04 Ending: 2/28/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercer County Nursing Home # 0001396 Report Period Beginning: 3/1/04 Ending: 2/28/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Farmers State Bank of Western IL		x	operating line of credit	n/a	1/23/04	\$ 350,000	\$	2/1/05	5.7500	\$ 5,275	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 350,000	\$			\$ 5,275	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 350,000	\$			\$ 5,275	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Mercer County Nursing Home**# **0001396**

Report Period Beginning:

3/1/04

Ending:

2/28/05**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2004 report.			\$	none	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	none	2	
3. Under or (over) accrual (line 2 minus line 1).			\$	none	3	
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	none	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	none	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	none	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	none	7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2000	_____	8			
	2001	_____	9			
	2002	_____	10			
	2003	_____	11			
	2004	_____	12			
				FOR OHF USE ONLY		
				13	FROM R. E. TAX STATEMENT FOR 2004 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mercer County Nursing Home COUNTY Mercer

FACILITY IDPH LICENSE NUMBER 0001396

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

A. Square Feet:
38,500

B. General Construction Type:

Exterior
brick

Frame
fire resistant

Number of Stories
one

C. Does the Operating Entity?

☒ (a) Own the Facility
☐ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment
☐ (b) Rent equipment from a Related Organization.
☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	facility	380,700	1966-1975	\$ 33,000	1
2	parking	28,800	2001	26,515	2
3	TOTALS	409,500		\$ 59,515	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercer County Nursing Home

0001396

Report Period Beginning:

3/1/04

Ending:

2/28/05

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	95		1970	1970	\$ 1,159,781	\$	35	\$		\$ 1,159,781	4
5				1972	7,968		20			7,968	5
6				1973	32,227		15			32,227	6
7				1974	12,959		15			12,959	7
8				1981	13,708	392	35	392		9,783	8
	Improvement Type**										
9				1982	277,094	7,490	15-35	7,490		194,699	9
10				1983	75,888	1,998	15-35	1,998		51,911	10
11				1984	11,380	227	10-35	227		8,419	11
12				1985	16,286	309	10-35	309		11,970	12
13				1986	30,658	600	15-35	600		21,063	13
14				1987	57,236	1,635	35	1,635		30,251	14
15				1988	47,170	1,348	35	1,348		23,587	15
16				1989	31,755	1,519	10-20	1,519		25,383	16
17				1990	96,237	3,721	20-35	3,721		54,358	17
18				1991	17,776	693	15-35	693		9,409	18
19				1992	4,113		5-10			4,113	19
20				1994	12,898	516	15-35	516		5,290	20
21				1995	21,981	1,107	15-20	1,107		10,490	21
22				1996	51,818	2,282	10-25	2,282		19,530	22
23				1997	32,019	1,682	10-35	1,682		13,045	23
24				1998	127,892	4,391	20-35	4,391		28,050	24
25				1999	5,665	283	20	283		1,699	25
26				2001	271,514	8,563	5-40	8,563		37,479	26
27		disallowed capital expenses		2001	205,383	5,134	40	5,134	(5,134)	21,394	27
28		floor		2001	1,713	86	20	86		350	28
29		condensing units		2001	31,250	1,562	20	1,562		5,729	29
30		sidewalk		2001	2,300	153	15	153		562	30
31		walkway		2001	11,982	300	40	300		1,049	31
32		disallowed capital expenses		2001	11,982	299	40	299	(299)	1,048	32
33		walkway		2003	2,730	68	40	68		142	33
34		expansion tank		2003	4,500	225	20	225		469	34
35		flange block		2003	649	65	10	65		124	35
36		dining room a/c repair		2003	740	37	20	37		62	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

****Improvement type must be detailed in order for the cost report to be considered complete.**

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 234,170	\$ 20,835	\$ 20,835	\$	5-20	\$ 149,254	71
72	Current Year Purchases	18,390	479	479		10	479	72
73	Fully Depreciated Assets	369,785	1,142	1,142		3-20	369,785	73
74								74
75	TOTALS	\$ 622,345	\$ 22,456	\$ 22,456	\$		\$ 519,518	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	activities/pt care related	2004 Ford van	2004	\$ 40,186	\$ 6,698	\$ 6,698	\$	5	\$ 6,698	76
77										77
78										78
79										79
80	TOTALS			\$ 40,186	\$ 6,698	\$ 6,698	\$		\$ 6,698	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,486,945	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 80,287	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 80,287	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,433)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,336,156	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	sprinkler	\$ 156,733	92
93			93
94			94
95		\$ 156,733	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2006 \$ _____

13. /2007 \$ _____

14. /2008 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p style="text-align: right;"> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO </p> <p style="font-size: small;">If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>no nurse aides were trained during this report period because the facility hired only aides who were already certified</u></p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
 SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 23,765	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	188,476		3
4	Supply Inventory (priced at <u>cost</u>)	25,013		4
5	Short-Term Investments	413,944		5
6	Prepaid Insurance	127,269		6
7	Other Prepaid Expenses	4,275		7
8	Accounts Receivable (owners or related parties)	18,465		8
9	Other(specify): <u>accrued interest</u>	29		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 801,236	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	59,515		13
14	Buildings, at Historical Cost	2,764,899		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	662,531		16
17	Accumulated Depreciation (book methods)	(2,336,156)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	15,985		21
22	Other Long-Term Assets (spe <u>farm investment</u>)	210,723		22
23	Other(specify): <u>construction in progress</u>	156,733		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,534,230	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,335,466	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 131,298	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	51,784		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,870		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>deferred revenue</u>	13,761		36
37	<u>accrued compensated absences</u>	148,407		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 350,120	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 350,120	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,985,346	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,335,466	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,093,531	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,093,531	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(355,628)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (355,628)	17
	B. Transfers (Itemize):		
18	transfers from county for FICA and IMRF	247,443	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 247,443	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,985,346	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1		Amount	
Revenue			
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,152,254	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,152,254	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	16,639	13
14	Non-Patient Meals	10,891	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 27,530	23
D. Non-Operating Revenue			
24	Contributions	7,523	24
25	Interest and Other Investment Income***	45,120	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 52,643	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	sale of supplies to residents	11,568	28
28a	miscellaneous	1,616	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,184	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,245,611	30

2		Amount	
Expenses			
A. Operating Expenses			
31	General Services	850,923	31
32	Health Care	1,627,772	32
33	General Administration	965,276	33
B. Capital Expense			
34	Ownership	85,562	34
C. Ancillary Expense			
35	Special Cost Centers	19,645	35
36	Provider Participation Fee	52,061	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,601,239	40
41	Income before Income Taxes (line 30 minus line 40)**	(355,628)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (355,628)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Mercer County Nursing Home# 0001396Report Period Beginning: 3/1/04Ending: 2/28/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,832	2,116	\$ 46,039	\$ 21.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,366	15,326	236,555	15.43	3
4	Licensed Practical Nurses	13,216	20,623	224,961	10.91	4
5	CNAs & Orderlies	84,871	118,102	881,220	7.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,954	2,247	24,035	10.70	9
10	Activity Assistants	5,986	7,438	55,003	7.39	10
11	Social Service Workers	1,570	1,834	23,569	12.85	11
12	Dietician					12
13	Food Service Supervisor	1,965	2,331	25,218	10.82	13
14	Head Cook	3,903	5,203	40,187	7.72	14
15	Cook Helpers/Assistants	13,334	17,927	100,552	5.61	15
16	Dishwashers	1,989	2,594	17,553	6.77	16
17	Maintenance Workers	1,934	2,034	27,536	13.54	17
18	Housekeepers	17,984	24,432	192,444	7.88	18
19	Laundry	2,590	3,421	30,823	9.01	19
20	Administrator	1,568	2,003	57,162	28.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,183	4,674	55,216	11.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	170,245	232,305	\$ 2,038,073 *	\$ 8.77	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	134	\$ 6,252	ln 1, col 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	900	ln 10, col 3	39
40	Physical Therapy Consultant	42	2,694	ln 10a, col 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	13	3,300	ln 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	201	\$ 13,146		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	340	\$ 14,620	ln 10, col 3	50
51	Licensed Practical Nurses	474	16,784	ln 10, col 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	814	\$ 31,404		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mercer County Nursing Home

STATE OF ILLINOIS

0001396

Report Period Beginning:

3/1/04

Ending:

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2/28/05

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. County Nursing Home Assoc \$880
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,460 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 52,061
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? n/a
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 10,891
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? yes
If YES, attach a complete explanation. see pg 21D
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? no
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Clifton Gunderson, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.